

FILED OCT 19 1945 STANDARD CERTIFICATE OF DEATH

34149

State File No. _____

Registration District No. 193

Primary Registration District No. 5701

Registrar's No. _____

1. PLACE OF DEATH:

(a) County McDonald
 (b) City or town Buffalo, TWP,
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME John Franklin Grife

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Sept, 30th, 1945
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____
 0 0 0 4 hr. 0 min.

9. Birthplace Near Goodman MO, _____
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Ava Grife

13. Birthplace Iowa
 (City, town, or county) (State or foreign country)

14. Maiden name Alice Brotherton

15. Birthplace MO
 (City, town, or county) (State or foreign country)

16. (a) Informant Ava Grife

(b) Address Goodman MO,

17. (a) Burial (b) Date thereof 10-1-1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson MO,

18. (a) Signature of funeral director C. W. Williams

(b) Address Goodman MO,

19. (a) 10/1/45 (b) James W. Williams
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County McDonald
 (c) City or town Rural, AR
 (If outside city or town limits, write "RURAL")
 (d) Street No. R.R.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
 year 1945 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from 9/30/45 19____ to 9/30/45 19____;
 that I last saw him alive on 9/30/45 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Unknown

A premature infant that never breathed
 Due to misc

Due to Premature

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Re. Jansen (M. D. or other)

Address Hereho MO Date signed 10/1/45

Duration

4 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

464

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2
-43
-39
135697

RECEIVED
District Health Officer No. 6,
District File Number 10451038
Date Filed OCT 16 1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.